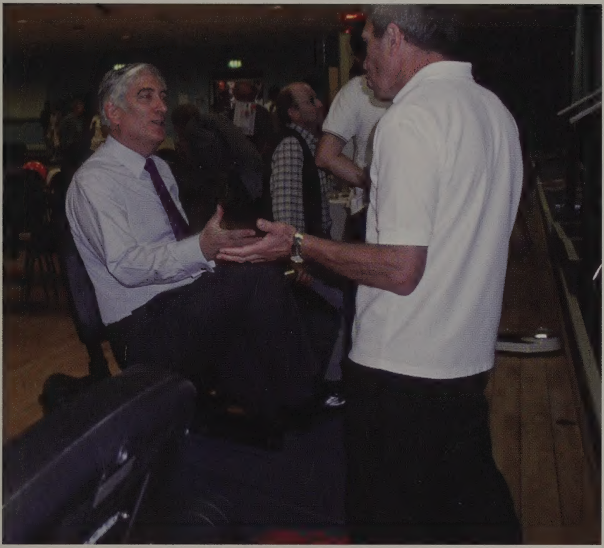
HEALTH AND SOCIAL SERVICES
A STATES OF GUERNSEY GOVERNMENT DEPARTMENT



107th ANNUAL MOH REPORT

12th ANNUAL DPH REPORT

Special theme:

The cost and quality of healthcare in Guernsey

Report for
Year 2005/06

HEALTH AND SOCIAL SERVICES DEPARTMENT

MEMBERS 2005-2006

Minister: **Deputy Peter Roffey**

Deputy Minister: **Deputy David Grut**

Members: **Deputy Hunter Adam**
Deputy Barry Brehaut
Deputy Mrs Diane Lewis

Non States Members: **Advocate Mark Dunster**
Mr Bruce Mansell

Front Cover
Front Cover (top)

Bailiff Geoffrey Rowland sets a healthy example by having his cardiac risk factors assessed at the *'Healthy Hearts'* open day held at *Beau Sejour* in September 2005.

Front Cover (bottom)

Joint working is what it is all about – Minister for Health and Social Services, Deputy Peter Roffey, and Minister for Education, Deputy Martin Ozanne present a *'Healthy Schools'* Certificate to pupils of the Grammar School on their achievement of the award on 18th October 2005.

All pictures courtesy of Mrs Steph Charlwood, Health Promotion Unit, PEH

Health and Social Services Department
A States of Guernsey Government Department

Political responsibilities:

Promoting, protecting and improving the health of all, through the provision of hospital, community, social and public health services.

Core principles:

In June 2004, the newly formed *Health and Social Services Department* agreed that in the provision and delivery of health and social care services:

- services should be 'user centered';
- service delivery should be 'seamless';
- services should be 'needs led';
- interventions should be 'evidence based';
- the rights and dignity of service users will be respected;
- vulnerable service users will be protected;
- services should be accessible, and non stigmatising;
- services should comply with 'good governance'

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Executive Summary

- This is the 107th Annual Medical Officer of Health (MoH) Report, and the twelfth Annual Report from Guernsey's first Director of Public Health.

- Past reports have generally reported on changes in the population health of the islands, and on those service developments considered necessary to better promote health and help prevent disease. In contrast, this Report has given a special focus to the *costs* of providing effective healthcare for an island population.

- The Report demonstrates that when compared with a range of other jurisdictions, Guernsey has a very moderate healthcare expenditure - both in terms of total spend and as a proportion of GDP.

- However Guernsey enjoys a *life expectancy at birth* (taken as a proxy for a range of environmental, lifestyle and health treatment factors) which is equivalent to other successful health economies, who are generally spending far more in real terms on their health and healthcare.

- At a *macroeconomic* level, it is therefore concluded that Guernsey enjoys a very good *'return on investment'* for its healthcare expenditure. Unfortunately, comparative *microeconomic* data (i.e. the cost of day to day operational running of the health service) is far less plentiful.

- However, examination of three such indicators – use of hospital beds, average length of stay (ALOS) for a range of conditions, and comparative staffing levels confirms that there do not appear to be gross inefficiencies, or opportunities for large scale cost savings within such 'headline indicators' in Guernsey's healthcare system.

- It therefore seems unavoidable that if Guernsey wishes to maintain its current favourable health outcomes, then it must expect to spend a slowly increasing proportion of GDP on healthcare. Whether such increases should be centrally funded, or come through increased personal contributions is a political question yet to be debated.

- The Report also reviews progress in the three core domains of public health – *health protection, health promotion,* and *the scope and quality of healthcare services.*

- Perhaps the greatest achievement of the past twelve months in public health terms has been the introduction of *'smokefree'* legislation ahead of many other European jurisdictions. The apparently smooth introduction of this measure owes much to the joint efforts of the Environmental Health Department and the Health Promotion Unit.

- Amongst looming public health threats is the likelihood of an influenza pandemic. With its close links with the global economy through international air travel, it is inevitable that Guernsey would be exposed to such a global pandemic, but probably several weeks behind major population centres. Integrated planning is now well advanced to try and minimise the impact of such an eventuality.

The cost and quality of healthcare in Guernsey

Introduction

Director of Public Health, Dr David Jeffs

Guernsey's health and social services exist, broadly speaking, to ensure that *'the greatest number of the population can enjoy the best achievable health and wellbeing at the most affordable cost'*.

The *Public Health and Health Strategy Directorate* makes a special contribution to achieving this end, specifically through:

- *Measurement*
  - Who falls ill?
  - Who needs hospital admission?
  - What is the average length of stay for specific causes?
  - The numbers and types of operations performed?
  - The causes of death?
- *Analysis*
  - How is the pattern of morbidity and mortality changing over time?
  - What is becoming more and what less common?
  - What changes are needed in health services to continue to provide the most appropriate services?
- *Research*
  - What is the most clinically effective way to prevent or treat a particular condition?
  - What is the most cost effective approach?
  - How strong is the *evidence* for preferring one approach over another?
- *Comparison*
  - How do patterns of morbidity, mortality, service utilisation and costs compare with other jurisdictions?
  - Are our rates of change comparable?
  - Are others doing things differently which might benefit Guernsey?
- *Advocacy*
  - However good the quality of the epidemiology, analysis and evidence, this will remain a largely academic exercise unless it translates to *'better health for a greater number at a more affordable cost'*.
  - How then do we persuade politicians and the public to support initiatives which will improve health in a more cost effective way?

This is my twelfth Annual Report as Director of Public Health. Previous Reports and related publications have largely confined themselves to considering changes in health status, and those service developments necessary to better promote health, and prevent disease. In contrast this Report gives a special focus to the costs of providing effective healthcare.

Since the early 1990's, Guernsey's economy has enjoyed particularly vibrant growth, and against this background, it has been difficult to argue politically that lack of finance was sufficient reason for not pursuing a desired health service development.

However, with the pending abolition of corporation tax, and the associated 'black hole' in States revenue, it has become essential to focus far more on the actual costs of delivering effective healthcare in Guernsey.

Guernsey is not alone in experiencing a constant upward pressure on healthcare costs. Health economists have noted over the past several decades, that total healthcare costs (whether expressed as a *per capita* spend, or as a percentage of GDP) have tended to rise ahead of RPI in all developed economies, irrespective of differences of structure, organisation or funding.

International and national organisations such the World Health Organisation (WHO), Organisation for Economic Co-operation and Development (OECD) and the Office of Health Economics (OHE) therefore routinely report and compare trends in these health economic variables across various countries and healthcare systems. Therefore when considering:

- the costs of healthcare in Guernsey
- the quality of health services we enjoy in return
- whether these represent good 'value for money'?
- whether there is excessive inefficiency in the system?

- we need very much to put Guernsey's healthcare costs into such an international perspective.

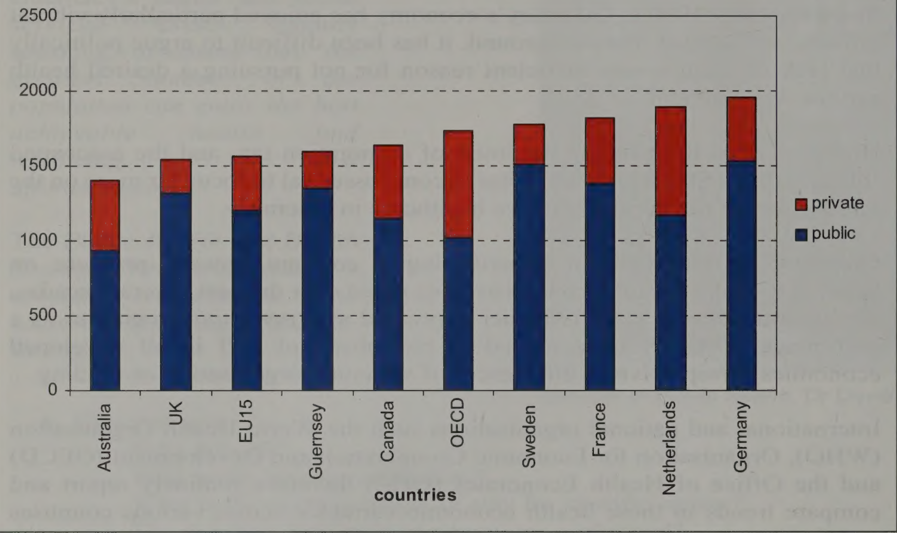
It is only by doing so that we can be sure that the good population health we currently enjoy comes *'at the most affordable cost'*.

Finally, once again I would like to thank all those who have contributed to public health initiatives in Guernsey and Alderney over the past twelve months, to the several contributors to this Report, to Mrs Steph Charlwood for the photos, Mrs Jenny Elliott for the various graphs and tables, and to my PA Mrs Yvonne Kaill for once again producing and collating the report.

Dr David Jeffs
Director Public Health and Strategy

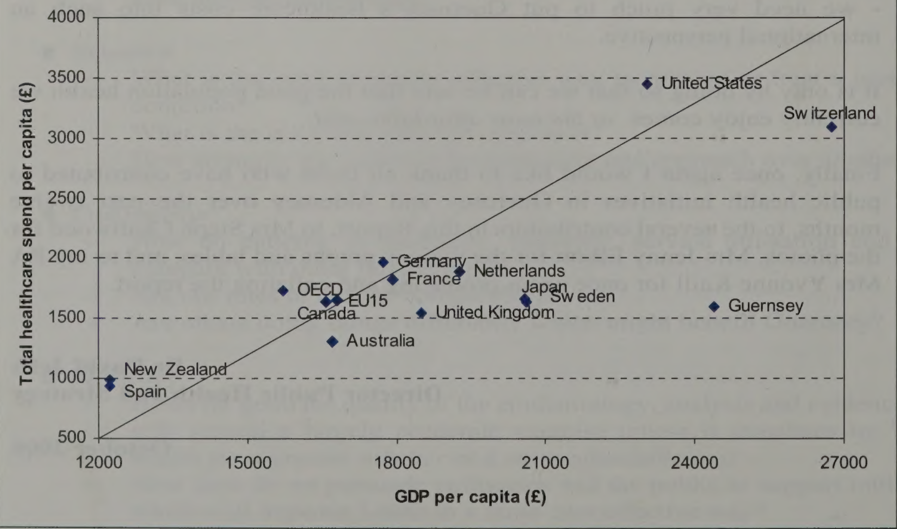
October 2006

Figure 1 - Total per capita health expenditure (GBP) - various countries and Guernsey 2003



Source: *Sustainable Guernsey* 2006

Figure 2 - Relationship between total *per capita* healthcare spend and *per capita* GDP in selected countries and Guernsey 2003



Source: *Office of Health Economics* (OHE)
Sustainable Guernsey 2006

The concept of *per capita* health expenditure *(Figure 1)*

A steady increase in the cost of delivering effective healthcare has been noted across almost all OECD countries. Health costs however, do not just come from 'one pot'. In all OECD countries there is a varying split between *public* (i.e. funded from taxes) and *private* (i.e. funded through health insurance contributions and personal expenditure).

In Guernsey, public expenditure includes the revenue budget given to the Health and Social Services Department, and components of the Social Security Department budget, including the Pharmaceutical Benefits Scheme (less prescription charges received), the Specialist Health Insurance Scheme, the '£12 States Grant' for primary care consultations, travel grants, Medical Expenses Assistance Scheme, etc.

Private healthcare costs can be estimated from the number of prescription charges levied, the residual cost of primary care consultations (on the basis of '£12' grants given), private health insurance costs, travel vaccination costs, etc. Such calculations suggest that the proportion of total healthcare paid for privately has fallen from around 21% of the total in 1994 to around 16% at present.

Figure 1 demonstrates that in 2003, (the most recent year for which all countries have data), *total* healthcare expenditure varied from £1,404 in Australia to £1,960 in Germany, and that the proportion which was non government funded from 15% in Sweden and the UK, to some 41% across the OECD as a whole. Although traditionally regarded as a 'private' system, only 16% of total healthcare expenditure in Guernsey is truly 'privately financed'. Further discussion on healthcare expenditure will be found in the most recent edition of *'Sustainable Guernsey'*.

The 'affordability' of healthcare costs *(Figure 2)*

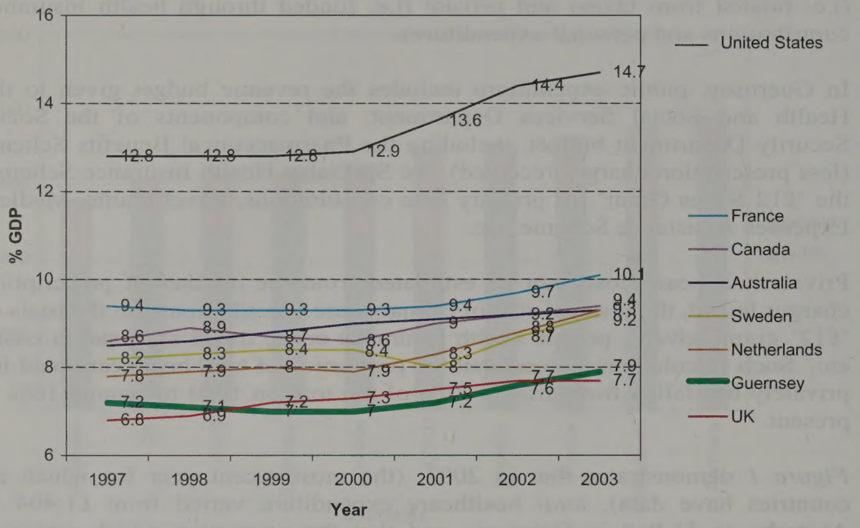
The variation in per capita healthcare spend has been noted above. Of perhaps more relevance is the *'affordability'* of this.

In economic terms, the two most important variables are how much we earn (per capita GDP) compared with what we choose to spend on healthcare (total per capita healthcare costs). *Figure 2* compares per capita GDP and per capita 'health spend' across a range of OECD countries and for Guernsey.

- It will be noted that some countries (such as the USA and Switzerland) enjoy a high GDP, and spend a large proportion of this on healthcare.
- Others (such as Japan and Sweden) have a relatively high GDP, but spend a lower proportion on healthcare.
- Some countries (e.g. New Zealand and Spain) have a more modest GDP, and spend a lower amount on health

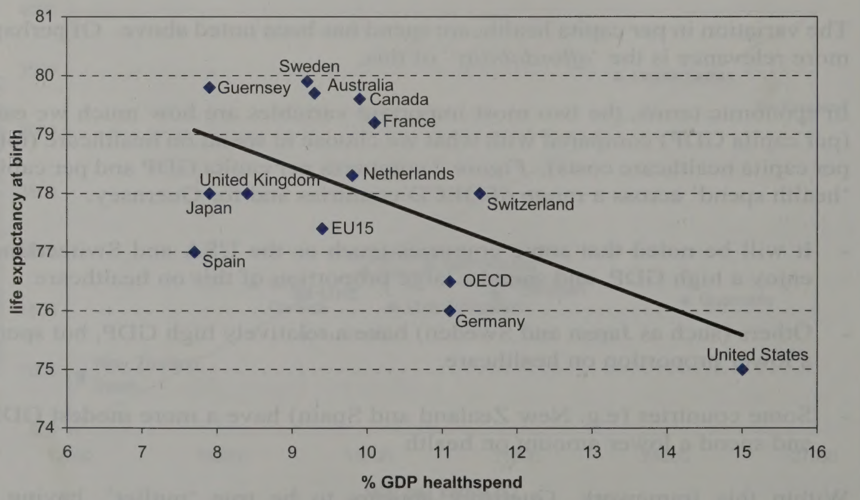
Within this framework, Guernsey appears to be true 'outlier', having a relatively high GDP *per capita* but a fairly modest total healthcare expenditure.

Figure 3 - Total expenditure on health as % of GDP selected countries and Guernsey 1997-2003



Source: OECD *'Health Statistics'* 2005

Figure 4 - % GDP total healthcare spend and life expectancy at birth in selected OECD countries and Guernsey 2003



Source: *Office of Health Economics* 2005-2006

Will healthcare costs continue to rise? *(Figure 3)*

Figure 3 shows that the percentage of GDP spent on total healthcare varies widely from around 7.8% (UK and Guernsey) to 14.7% (USA).

Most European countries appear to spend between 9% and 10% of GDP on total healthcare, but whatever the proportion, all countries have demonstrated a similar proportionate rise over the past decade. Even countries such as Sweden, who have attempted to 'rein in' healthcare expenditure, have shown later *'catch up'* growth.

Given the pressure such increases place on national economies, possible explanations have been much studied and debated. These include:

- The 'ageing of the population'.
- New or more virulent diseases such as HIV/AIDS and MRSA .
- Technological change – new medicines, new surgical techniques and so on.
- Avoidable administrative expenses and other systemic inefficiencies.
- 'Excessive profits' for pharmaceutical and other medical suppliers.
- Greater expectations from the public.
- A higher *'perceived value'* placed on health.

The exact contribution by each of these components was the subject of a comprehensive review *'Spending on healthcare – how much is enough?'* published by the Kings Fund in February 2006.

Because of the *'compression of morbidity'*, the ageing of the population is felt to be a comparatively minor component of the overall rise in healthcare costs.

The main 'driver' appears to be due to 'technological change' i.e. new medicines, new surgical techniques, etc are more effective but cost a lot more. The Kings Fund study suggested that these may contribute between 50-65% of the total growth.

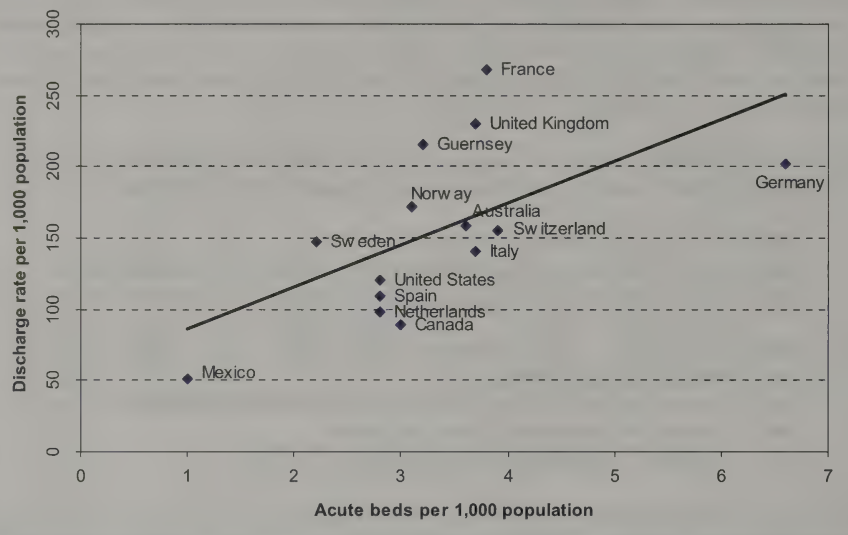
The other major contributing factor appears to be growth in income, because *'as people become richer, they are willing to pay more for a given improvement in health.'* Higher costs, in other words, are offset by an increase in perceived 'value'.

If people want the latest treatment, and are prepared to pay more to receive it, then it seems almost inevitable that total healthcare costs will continue to rise above RPI for the foreseeable future.

Does greater spending lead to better health? *(Figure 4)*

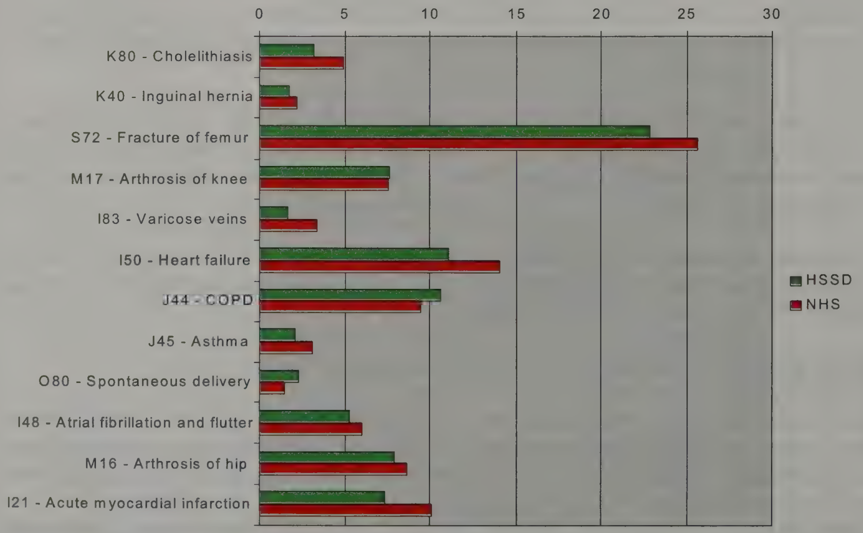
Life expectancy may be defined as *'the average number of years that a person can expect to live if they experience the current mortality rate of a population at each age'*. There are many factors which may affect this, ranging from environmental factors (such as population density, air pollution, etc), to lifestyle choices (smoking, diet and weight), as well the provision of adequate health services (such as hospital and community based facilities and welfare provisions).

Figure 5 - Acute bed provision and hospital discharge rates in selected OECD countries and Guernsey 2003



Source: OECD *'Health Statistics'* 2005-2006

Figure 6 - ALOS (days) for selected admissions Guernsey and NHS compared 2005



Source: *NHS HES* data 2006
Healthcare Information Unit, PEH 2006

Life expectancy has been increasing by approximately one year every five for the past several decades. For example, male and female life expectancy in the UK in 1950-1955 was 66.74 years for men and 71.8 years for women. By 2000-2005 it had risen to 75.9 years for men and to 80.6 year for women.

Life expectancy in Guernsey on the basis of the 2001 Census population and all deaths occurring in calendar year 1999-2003 was calculated at 77.5 years for men and 82 year for women - around two years more than the UK average. *Figure 4* demonstrates that whilst Guernsey's total healthcare spend as a proportion of GDP is amongst the lowest in Europe, life expectancy compares well with the best.

The inter-relationship between increased life expectancy and total healthcare spend has also been the subject of much study and debate.

In the King's Fund review mentioned above, it is postulated that healthcare like other expenditure, tends to follow a model of *'diminishing returns'*, i.e. an initial increase in spend produces a large 'return on investment', but the curve gradually flattens, and eventually becomes negative (for example, spending large amounts keeping very premature infants alive may offer little increase in survival, but cost much in terms of increased pain, suffering and anxiety for both infant and parents - a *'negative return'* in terms of health benefit).

Economists have suggested that the early 'big wins' are due to relatively cheap and easy to introduce 'public health' measures, such as universal vaccination, access to primary care, etc. They feel that most of the improvements in life expectancy up until the mid-1970's were due to such factors.

More recently, more expensive technological change has led to increasing, but lesser improvements in health.

For example, looking at the 50% fall in cardiac deaths that have occurred over the past 30 years, they suggest that one third of this may be attributable to behavioural change, which is relatively 'cheap', (e.g. reduced smoking levels, more 'low fat' dietary choices, etc), one third to increased use of better (and generally affordable) medicines, (e.g. more effective antihypertensive agents, statins for blood fat lowering, etc) and one third from more effective but more expensive acute care (e.g. better ambulance retrieval, early thrombolysis, specialist coronary care, cardiac surgery, etc).

Are there significant inefficiencies in Guernsey healthcare? *(figures 5-7)*

It is hoped that the preceding paragraphs and associated figures will have confirmed that in *macroeconomic* terms, Guernsey appears to get excellent health outcomes for a moderate health investment. Even accepting that part of this is due to the general affluence of the island, most health economists would also argue that an increasing component of this health gain can be shown to be linked to the availability of more effective healthcare services.

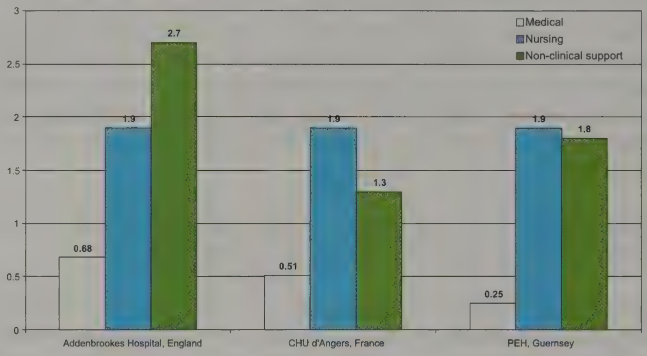


Figure 7 - Ratio of staff per acute hospital bed England, France, PEH Guernsey 2004

For *macroeconomic* comparisons, there is an abundance of international data available from the WHO, OECD, OHE, etc. Because of the differing natures, structure and funding of healthcare systems, it is far more difficult to find comparable data for *microeconomic* healthcare expenditure, i.e. the cost of day to day operational running of the health services.

In this context, it is perhaps worthwhile further examining three facets of healthcare:

- Use of hospital beds
- Average length of stay (ALOS) for a range of conditions
- Comparative staffing levels

Acute bed provision and hospital throughput *(figure 5)*

Acute hospitals exist to admit, investigate and treat illness and disease as efficiently as possible. An acute hospital bed (rather like an airline seat) represents a *'fixed cost'* – it needs to be paid for whether it is used or not. Therefore anything which helps increase through-put such as increasing 'day only' procedures, implementing discharge planning, etc, makes for the most efficient use of this resource.

In 2004 there were 169 acute beds and 24 'day only' beds at the Princess Elizabeth Hospital (PEH) - a total of 193 acute use beds. In that year, there were also 7,120 acute admissions plus 5,746 'day only' procedures – a total of 12,866 discharges.

Comparative figures showing the relationship between *'acute bed provision'* and *'hospital discharge rates'* for selected OECD countries are shown in figure 5.

Because of its high 'day only' rate (43% of all admissions compared with 29% in the NHS) Guernsey is able to demonstrate high activity levels compared with its acute bed provision. It should be noted that no 'tertiary level' care (which tends to be more complex with longer ALOS) is performed in Guernsey.

Average length of stay (ALOS) for selected conditions *(figure 6)*

A further comparison of ALOS between the PEH and the NHS is shown in figure 6. It is important to compare *'like with like'* (given that tertiary level procedures are not performed in Guernsey).

Therefore the twenty most common causes of admission to the PEH were taken, those that might be subject to differences in coding excluded (e.g. *'investigation of abdominal pain'*), and the remaining twelve causes of admission compared with NHS HES (Hospital Episode Statistics) data.

This shows that for most common conditions, with the exception of COPD (chronic obstructive pulmonary disease) and spontaneous delivery, Guernsey had a lower ALOS. Given the well publicised concerns about NHS waiting lists, it may well be that NHS patients are older/sicker by the time they are admitted for treatment?

Staffing levels *(figure 7)*

Staffing costs generally comprise around two thirds a typical healthcare budget, but surprisingly there is very little validated data to allow direct international comparisons.

One such study published earlier this year, compared staffing levels at Addenbrookes Hospital Cambridge (1,110 beds), with CHU d'Angers in the Loire region of France (1,500 beds). Equivalent staffing levels for the PEH (193 beds) have now been added. Both Addenbrookes Hospital and CHU d'Angers are University teaching hospitals and tertiary referral centres.

The ratio of doctors at the PEH is calculated to include all MSG consultants, pathology, radiology, and the full time equivalents (FTE) for A&E doctors. Guernsey does not have any junior medical staff, and much of the routine ward work done by SHO's and Registrars in the NHS will be performed by nurses in Guernsey. There are 370 nurses employed on the acute wards, theatres, 'day only' and A&E departments at the PEH.

The 353 *'support staff'* include porters, cleaners, laundry, kitchen, maintenance, hospital accounts, health records, clerical, clinical audit, clinical risk management, etc, but excludes professional staff such as radiographers, the laboratory biomedical scientists, therapists, etc. Guernsey also suffers necessary *'diseconomies of scale'* because of the need to staff for 'peaks' of activity in smaller departments.

On this basis it will be noted that:

- Guernsey has comparatively fewer doctors per acute bed, but then has no junior medical staff and does not deliver tertiary level care.
- Nursing staff levels are almost identical across all three hospitals.
- 'Support staff' at the PEH are only 67% of the NHS comparator, and although higher than France, the *'diseconomies of scale'* of a smaller hospital are contributory.

- Although the HSSD has previously been accused of employing *'an army of pen pushers and bean counters'*, given the *'diseconomies of scale'* referred to above, there is little evidence of this at the PEH at present.

Conclusions

In summary it can be stated that:

i. A country's *health* is positively linked to its *wealth* – higher levels of an 'equitably distributed' GDP imply a better *'standard of living'* (including better housing, nutrition, education, environment, infrastructure, etc) for many of the population.

ii. As GDP increases, spending on healthcare preferentially increases, i.e. populations throughout the industrialised world have demonstrated (often through the ballot box) that they value *'life'* and the services that extend it over other use of resources. This may be seen as a rational and predictable response to rising incomes.

iii. A greater proportion of GDP spent on health does not necessarily produce 'better health' as measured by such proxies as *'life expectancy at birth'*, e.g. the USA spends a high proportion of GDP, but has a comparatively lower life expectancy than countries such as Sweden, France and Australia which spend a lesser proportion of GDP on health, but have more equitable access *(figure 4)*.

iv. Healthcare expenditure also improves less easily measured, but still desirable outcomes such as *'quality of life'* through reduction in pain and discomfort, etc.

v. There is good evidence that increased healthcare spending has delivered significant health gains in the recent past, but that this rate of improvement may now be slowing.

vi. Nonetheless, the experience of almost all developed economies is for a greater proportion of GDP to be spent on health, because as incomes rise, better health and healthcare is what the electorate increasingly demands.

On this basis, Guernsey may be seen to enjoy a very good 'return on investment', spending a comparatively low proportion of GDP, but enjoying a *'life expectancy at birth'* equivalent to other successful health economies.

However, given the upwards trends on cost pressures in health, it would be naïve to expect that Guernsey can continue to enjoy such favourable health outcomes if total spend on healthcare is allowed to significantly deteriorate. Whether such an increase should be centrally funded, or be financed through increased personal contributions, is a political question yet to be debated.

Guernsey's private health contributions are currently (along with Sweden and the UK) amongst the lowest in the OECD, but any moves to try and maintain an adequate healthspend through an increase in personal healthcare contributions would affect equitable access, and would certainly not be popular politically.

The work of the Directorate

In the last annual DPH Report (2004/2005), it was suggested that there were three separate (but overlapping) *core domains* to public health, i.e. areas where public health skills such as epidemiology, biostatistics, and evaluation of 'healthcare evidence' have a special contribution to make.

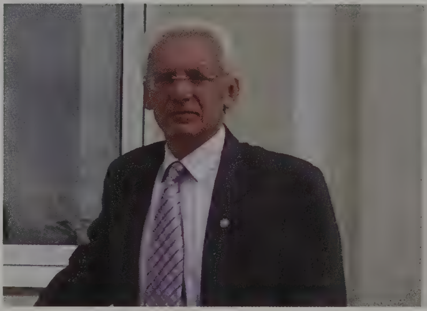
The work of the *Public Health and Health Strategy Directorate* over the twelve months 2005-2006 will now be considered under these headings.

1) Health Protection

Environmental Health

The former Environmental Health Department (now officially renamed the *Department of Environmental Health and Pollution Regulation*) is now well settled in its purpose built new home at Longue Rue, St Martins.

Achievements during 2005/2006 include;



Mr John Cook Director of Environmental Health and Pollution Regulation (Designate)

- *'Smokefree'* Guernsey

The Chartered Institute of Environmental Health (the main professional body for Environmental Health Officers) has placed the need for *smokefree* enclosed public and workplaces high in its agenda. The Environmental Health Department was active in arranging for a representative of the Institute to visit Guernsey to explain to States members and the media the scientific rationale for *smokefree* enclosed places, in the introduction of *smokefree* areas on all Health and Social Services Department premises, and in the implementation of *smokefree* legislation in the wider community.

- The *Control of Environmental Pollution Law* 2004 has now commenced having been initially agreed by the States of Deliberation in February 1997.

- *Private sector rented accommodation* - concern remains about the high rents and poor repair of some private sector rented accommodation, although numbers reported to the Department as such continue to decline. The Environmental Health Department has been involved in a cross-departmental initiative to develop a voluntary code of standards for private rented accommodation.

- *Sewage treatment* - the discharge of raw macerated sewage into the Little Russell continues to cause concern to many Guernsey residents. The Department has attempted to maintain an objective stance, and whilst not condoning the practice, has tried to ensure that possible health risks are seen in a proper perspective.

- **Food safety**

The Department promoted food hygiene awareness by implementing the Food Standards Agency "Safer Food, Better Business" initiative, running seminars and distributing free business packs to compliment the Department's formal training programme. Additionally, new licensing legislation means that there are now better environmental health controls on licensed premises, particularly those serving food.

States Analyst Laboratory

- The States Analyst Laboratory is also well settled in its new premises in St Martins. Where possible, equipment and furniture from the old laboratory have been re-used.
- The laboratory is externally accredited and continues to meet all quality standards required.
- Of some concern is the lessening workload brought about in part by other States Departments 'rationalising' their workload in the light of pressure to cut costs.

Dr David Mortimer, States Analyst

- Because laboratory operating costs continue to rise, the time is approaching when Guernsey must decide whether it wishes to retain its own States Analyst Laboratory. Although there may be savings to individual States Departments, it could well be that the overall costs to Guernsey would be higher, whilst important results might be delayed due to adverse weather conditions.

Communicable disease

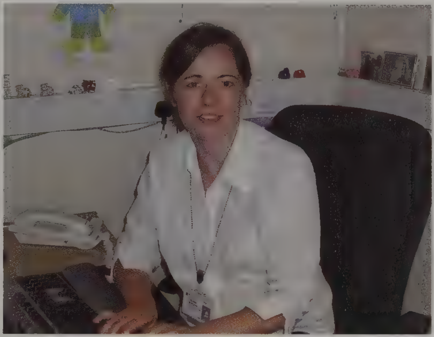
Dr Brian Parkin, Deputy MoH

- Most causes of communicable disease in the community continue to decline. Only 9 cases of mumps were notified in 2005, compared with 39 in the much publicised mumps outbreak during the previous year.
- Similarly, notifications of food poisoning at 114 were the lowest for many years, and less than half of the 246 cases recorded in the year 2000.

- Levels of tuberculosis continue to give concern, with 3 new cases, 19 'contacts' of such index cases, and an increasing number of people requiring Mantoux testing or BCG vaccination, due to work or travel requirements. A total of 182 attendances were recorded at the TB clinic, involving 73 different individuals.

Infection control

- The Infection control team based at the Princess Elizabeth Hospital now works increasingly closely with the Deputy Medical Officer of Health, and are responsible for infection control, both across *Health and Social Services Department* premises and also in the wider community.



Mrs Elaine Burgess,
Lead Infection Control Nurse

Other highlights have included:

- *Infection control* awareness week.
- Introduction of an infection control newsletter.
- Implementation of four new infection control policies, with ability to access a total of 14 such policies via the intranet.
- Introduction of seven new infection control patient information leaflets, making a total of 35 such leaflets.
- Pandemic influenza planning.
- Almost 300 hours of infection control educational sessions.
- Continuation of the annual infection control audits in acute, primary care and nursing home settings.
- Increasing the number of communicable disease databases.
- Introduction of a pre-operative orthopaedic MRSA screening programme.
- Introduction of an 'MRSA pathway'.
- Supervision and control of 25 separate communicable diseases outbreaks,

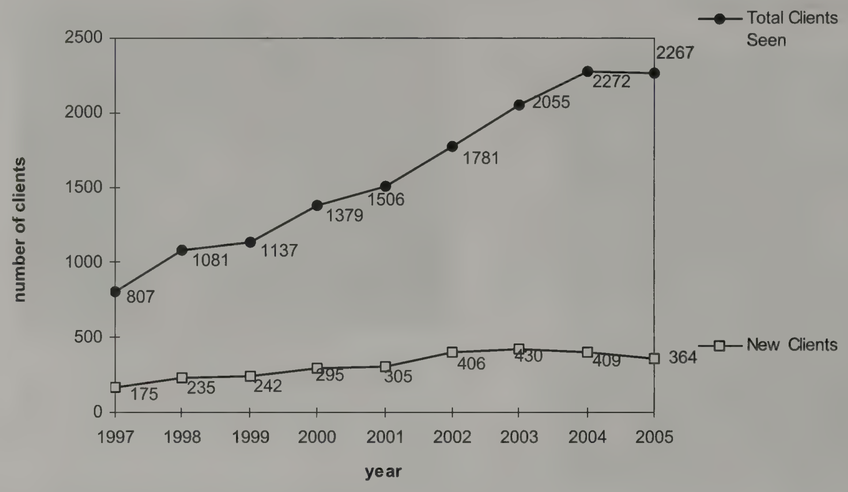
International Health Regulations (IHR)

The new IHR were agreed by the World Health Assembly in May 2005, and are due to come into force on 15th June 2007.

The UK Government has indicated that it wishes to accept the new IHR 'without reservation' and states *'the new IHR should be such that the Overseas Territories should be able to adopt them'*.

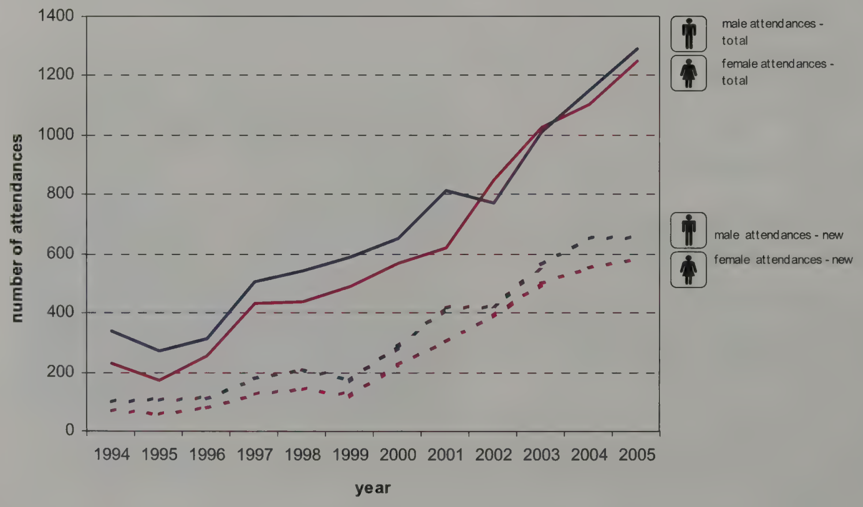
A multi-professional working group has therefore been looking at the implementation of these in Guernsey. Important issues to address include port control, surveillance, notification, quarantine, evacuation and requests for expert help.

Figure 8 - Guernsey Family Planning Clinic new and total clients seen 1997-2005



Source: Family Planning Clinic - Guernsey figures 1997-2005

Figure 9 - Sexual Health Clinic - Guernsey male and female attendances 1994-2005



Source: Sexual Health Clinic - Guernsey figures 1994-2005

Sexual Health and Family Planning

There has been a major liberalisation in sexual attitudes in Britain over the past decades. Recent surveys confirm that the mean number of *'lifetime sexual partners'* in the UK has increased by around 50% for men and by over 75% for women over the past ten years, whilst the practice of 'safer sex' has declined. At the same time the median age of first intercourse has fallen from 17 to 16 years in both sexes. The result has been a huge increase in adolescent conceptions, adolescent terminations of pregnancy and sexually transmitted diseases in the UK.

Although we do not have recent data on local sexual attitudes and behaviour, all evidence suggests that trends in Guernsey parallel those in the UK, although they may lag several years behind. Certainly, both the Family Planning Clinic *(figure 8)* and the Sexual Health Clinic *(figure 9)* can demonstrate huge increases in attendances.

The Family Planning Clinic, the Sexual Health Clinic, and the gynaecological and urological services provided under the MSG contract all have very different histories, and have to a large extent developed as separate entities.

Against the background of rising demand, a number of practitioners involved in the planning and delivery of sexual health services (broadly defined) have been meeting for the past four or so years to produce a Guernsey *'Sexual Health Strategy'*.

The major challenge is how to balance a steadily rising increase in demand against a more modest growth in the resources available to sexual health.

The *Sexual Health Strategy* is a consensus document which was accepted by the *Health and Social Services Department* Board in June 2005. Although not endorsing a definitive plan, the Strategy supports:

- Early and adequate investment in sexual health services which helps prevent more serious problems in the future. These may include pelvic inflammatory disease, tubal pregnancies, and infertility.

- Many sexual health problems can be adequately dealt with at a primary care level, although issues of confidentiality and *'fee for service'* may make this less attractive for some.

- The management of more complex conditions, such as gonorrhoea, syphilis, HIV/ AIDS and other blood borne viral diseases are beyond the competence of many general practitioners and should be regarded as 'secondary level services', and be managed by a practitioner with special skills in this area.

- An early result of the acceptance of the *Sexual Health Strategy* has been an increase in funding for both the Family Planning and the Sexual Health Clinics to help cope with this increase in demand. A longer term solution still requires agreement.

One measurable outcome of effective sexual health services will be a containment of abortion rates.

Despite predictions that Guernsey's 1997 *Abortion Law* would result in a steady increase in the number of abortions, 2005 figures record 126 terminations performed on island and a further 9 abortions performed in England and Wales for women giving a Bailiwick address.

This represents a total of 135 abortions during 2005, - a rate of 11 per 1,000 resident women aged 15-44 years. This is only 62% of the equivalent figure for England and Wales, where the standardised abortion rate was 17.8 per 1,000 resident women aged 15-44 years in 2005. It also shows little change from the abortion rate prior to the 1997 Law, when abortions on local women performed 'off island' varied between 110 and 155 annually.

Emergency planning and major incident response

- **Potential terrorist action**

In the wake of the 11th September 2002 attacks in the US, and the 7th July 2005 bombings in London, all Governments have become more aware of the need for adequate preparedness for such events. Because of the possibility that biological, chemical or nuclear materials might be used, public health personnel have been closely involved in such planning. The success of such involvement was borne out by the rapid and largely effective responses to the London bombings.

Although Guernsey is unlikely to be a primary target for such a terrorist attack, we nonetheless need to ensure that we are not totally unprepared. A component of nuclear, biological and chemical preparedness has therefore been incorporated into Guernsey's *Major Incident Plan*. Jersey and the Isle of Wight have already tested their local plans through 'live' exercises, and it is hoped that Guernsey will also be able to do so.

- **Pandemic influenza**

Not all catastrophes need be manmade. Since there has been no outbreak of pandemic influenza since the 'Asian Flu' in 1956/1957 and the Hong Kong Flu in 1967/1968, epidemiologists calculate that a large proportion of the world's population will have no natural immunity to many common serotypes of influenza virus, and any new influenza virus mutation would spread rapidly from rural areas to major population centres.

The Department of Health in London estimate that up to 25% of the UK population might suffer serious clinical illness for a week to ten days as a consequence, with a proportion dying as a result. Without adequate preparation, both numbers affected and mortality levels will be higher than need be, health services could be overwhelmed, and even maintaining vital services and community infrastructure might prove problematic. The Public Health Directorate has taken a lead role in planning for such a medical emergency, the effectiveness of which will only become apparent should the predicted pandemic occur.

2) *Health Promotion*

- ***'Smokefree'* health premises and *'Smokefree'* Guernsey**

Perhaps the greatest achievements have been the successful implementation of an internal *'Smokefree'* environment across all *Health and Social Services Department* premises on 1st January 2006.

This was followed by close working with the Environmental Health Department to ensure successful implementation of the *'Smokefree'* law across Guernsey on 2nd July 2006.

Miss Yvonne Le Page
Health Promotion Manager

- ***'Choosing Health' - public and professional consultation***

Health promotion is sometimes somewhat unfairly portrayed as *'the nanny state in action'* and *'always telling people what they should do, and what is good for them'*. In reality, politicians are unlikely to support, and the public unlikely to follow health promotion advice unless it equates with their own perceptions of what is important and achievable in pursuit of a healthy lifestyle.

Guernsey is fortunate in that we have been able to develop very good local health data, and this is regularly summarised and reviewed. The most recent five year review of health and healthcare in Guernsey was published under the title *'Healthier Islands' revisited* in September 2005. Following a previous *'Health – your choice'* exercise held late in 2000, 74 informed local 'opinion leaders' were invited to attend one of four 'health priority setting' sessions, of whom 58 people (78.4% of those invited) accepted.

There was much lively discussion at the various sessions, but remarkable congruency of outcome across all four groups, with the top five health promotion priorities in all groups being:

- Mental and behavioural problems due to alcohol
- Emotional problems in childhood and adolescence
- Sexual health
- Childhood obesity
- *'Work life balance'*

There are already a number of initiatives in these areas (e.g. the forthcoming States *'Drug and Alcohol Strategy'* Report, implementation of the new *Children* legislation, the *'Sexual Health Strategy'*, the *'Nutrition Exercise and Weight Strategy'* (NEWS) – see below, etc).

The new 'top ten' will be used to help guide the work of the Health Promotion Unit over the next five years and also inform other departments and organisations of current priorities. It is felt that a focus on those health promotion priorities which align with people's perceptions of changing health needs are most likely to enjoy wide support from the public.

- **Nutrition Exercise and Weight Strategy (NEWS)**

The rise in both childhood and adult obesity has extremely worrying consequences for the future health of the island. The Health Promotion Unit researched the production of 'NEWS' (*Nutrition Exercise and Weight Strategy*), which has now been agreed by the *Health and Social Services Department* Board and will shortly be sent for consultation to stakeholders amongst other States departments, including Commerce and Employment, Education, Environment, and Recreation and Leisure, with medical and health professionals, sports organisations and also across the wider community.

- ***'Healthy Hearts'* Month**

Another successful *'Healthy Hearts'* month was held in September 2005 and focused on a variety of activities to better identify and prevent various aspects of heart disease. These included training sessions, media work and activities for the general public, culminating in an 'Open Day' at Beau Sejour, which was opened by the Bailiff.

- ***'Walk your way to health'***

This free walking programme has continued from strength to strength. Each of the five daily walks regularly attracts an average of 20 walkers, and there are now 40 volunteer leaders. This has meant the programme has been able to expand to include Thursday evening and Sunday afternoon walks.

- ***'Healthy Schools'* programme**

A further six schools have achieved the National Healthy School Standard in the last 12 months. The Unit has worked closely with Mrs Ann Battye – PSHE consultant whose post is part funded by the tobacco Strategy and they have made real differences to both the taught curriculum and daily life of children in these schools. A further development of the programme has been the introduction of the DfES Certification of PSHE courses for teachers and community nurses.

- **Guernsey *'Quitline'* expanded**

'Quitline' has seen a huge increase in the number of clients attending their sessions. By the end of June 2006 they had had 570 new registrations – an increase of almost 200 on the previous year. A large part of this was felt to be due to smokers deciding to 'quit' in the run up to the *'Smokefree'* legislation.

Quitline has also employed 2 part-time advisors specifically to work with young people and pregnant mothers, two of the groups in which there has been a less marked drop in the proportion of smokers.

‘Health Promotion’ in action 2005 – 2006

Guernsey Fire Officers prepare the banner promoting Smokefree Guernsey to hang over Smith Street before July 2nd

John Webb, Drug Concern, shows two of the School Nurses how to identify illegal drugs as part of their PSHE certification

Some of the *Choosing Health* participants

Lucy Whitman receives her Health Promotion diploma from Yvonne Le Page

Yvonne Le Page and Yvonne Kaill calculate the scores from the Choosing Health forum in January

Steph Charlwood started running Bodybalance© classes for hospital staff to help keep them healthy and reduce their stress levels

Sam Marsh, Live for Life tutor, gives healthy lifestyle advice at the Bowel Awareness Day, Day Patient’s Unit, in April

Di Lawrence, GASP Project Co-ordinator, demonstrates one of her lessons

Guernsey Adolescent Smokefree Project *(GASP)*

Mr Alun Williams, Chairman and Miss Di Lawrence, GASP Project coordinator

- Two new project workers were appointed in September- Di Lawrence and Karen Le Marchant, and they have continued to develop and improve the *GASP* teaching programme in schools.

- *GASP* has also been involved in a number of external projects including running a competition for children to nominate their favourite adult who had given up smoking, helping to organise the *Smokebusters* fun runs and supporting the implementation of *'Smokefree'* legislation.

- Chairman Alun Williams was invited to speak on the Guernsey experience at several conferences in the UK and presented to the tobacco expert group of the Scottish parliament. GASP also received a special award for its ambassadorial activity at the *Guernsey Awards for Achievement*.

Cardiac Rehabilitation

- Cardiac rehabilitation tutors ran 5 sessions each week, to which an average of 30 clients attended in total. New clients increased to over 120 during the year.
- It was finally agreed to appoint a specialist cardiac nurse to support the service and Sophie O'Connell will take up the post in August.

3) The scope and quality of clinical services

Health Records

- Well managed, well maintained and easily accessible health records underpin effective clinical care. At one time the medical record was often little more than a handwritten *'aide memoire'* for a single clinician.

- Now increasingly, healthcare is delivered by multi-professional teams, complaints and legal action are becoming more common, and the need to demonstrate 'quality of clinical care' against a background of rising healthcare costs is an imperative.

Mrs Jenny Powell
Manager, Health Records

- Consequently, health records have grown in size and complexity, sometimes reaching three or more volumes - each equivalent to the size of a Guernsey telephone directory. Portions of the health record can also be stored in up to thirty-four different locations around *Health and Social Services Department* and other premises. Such growth leads to the potential for important information to be missed or lost. To better cope, the health records department has:

- adopted a policy of eliminating non-essential clinical material after eight years.
- arranged for additional shelving to be built in the health records department
- charging for the release of records, with the money gained enabling temporary staff to be employed to clear backlogs of filing, etc.
- ensuring an adequate staffing structure, with a deputy to the health records manager now appointed.

- All staff continue to work hard to improve the reputation of the department, and have many suggestions on how to improve their working environment and better work together as a team.

Clinical coding

To translate the largely unstructured clinical information contained in the health record into a form in which it can be analysed and utilised for essential *'secondary uses'* such as operational management, quality assurance, consultant appraisal and revalidation, and longer term strategic planning requires timely, accurate and expert clinical coding.

- **Coded Episodes**

The Clinical Coding department were responsible for coding almost 14,000 acute hospital episodes across all specialties in 2005. With two WTE clinical coders, this equates to almost 7,000 episodes per coder, with the capacity to enter up to 13 separate diagnostic codes and 13 separate surgical codes. The department continues to maintain its high quality work, whilst dealing with high volumes and increasing complexity.

- **OPCS 4.3**

The release of OPCS *Classification of Interventions and Procedures Version 4.3* has been welcomed by the clinical coding department. Version 4.3 has been developed to improve coding detail and facilitate the recording of interventions not previously covered in OPCS Version 4.0. Version 4.3 sees the expansion of most chapters to include new procedures, the addition of Chapter U – Diagnostic Imaging, Testing and Rehabilitation, and the facility to record high cost drug treatments, including chemotherapy.

Although OPCS Version 4.3 will not be incorporated into the current EDS *Patient Administration System* (PAS), it will be implemented with the planned electronic health and social care record.

Electronic health and social care record (EHSCR)

- Continuing growth of the numbers, size and complexity of the paper-based health record is obviously unsustainable. The need to replace the hospital PAS which will shortly no longer be supported by its suppliers, has led to a commitment to *'go paperless'*.

- Planning is well advanced, and a 'preferred supplier' has been identified to allow Guernsey to implement an integrated *'electronic health and social care record'* over the next 3 – 5 years.

- Such a system has the potential to:

- ensure that essential clinical information is available wherever and whenever it is needed;
- ensure that *'Caldicott'* confidentiality principles are properly applied so that service users can have full confidence in the confidentiality and security of their health records;
- with the implementation of the EHSCR, staff will only be able to access health records on a 'need to know' basis and only for that amount of information necessary for a particular task;
- the 'secondary uses' of healthcare information will become much more streamlined, with such data all being collected as part of the day to day clinical process.

Healthcare Information

- **Cancer data**

Guernsey cancer registry data previously relied on hand completed forms - a time consuming approach which frequently led to incomplete data. The Healthcare Information Department has now established a *SQL Server* registry for pathology, inpatient and outpatient data relating to cancer patients in Guernsey.

Mrs Allyson Byrom
Healthcare Information Manager

All data is now captured electronically allowing far more efficient tracking of cancer incidence, prevalence, effectiveness of treatment and for monitoring of length of survival.

- **Deaths data**

Guernsey death registry has now been migrated from Microsoft Access to *SQL Server* streamlining the application by storing this data in the healthcare information data warehouse. Cause of death can now be linked to other related healthcare events such as theatre visits and inpatient episodes.

- **Service reviews and consultant appraisals**

Development work in *Business Objects* continues and reports have now been designed for all consultant appraisals and all ongoing service reviews. This has enabled the department to produce the reports far more quickly to meet the requirements of those specialists undergoing appraisal early in the year.

- **Off-island Data**

The department has now obtained a considerable amount of data relating to treatment of Bailiwick residents in England. Work is continuing to improve the quality and format of this data to enable a full analysis across all providers. Since off-island referrals now account for some 10% of the healthcare budget, it is important to know who is referred, why, and how treatment outcomes compare with what might be provided locally.

Clinical Audit

- The two clinical audit nurses continue to be extremely busy encouraging, facilitating and supporting clinical audit activity across a range of departments. Highlights include:

- The new algorithm for management of a patient with *deep vein thrombosis* (set up in September 2004) was audited over a 6 month period. Results showed that of all patients investigated with venous Doppler ultrasound, venometry or both, only 11% proved to be positive. There were no cases of false negatives. This has led to further streamlining of the service, and more concise guidelines for patient treatment.

- *National Service Framework for Coronary heart Disease.*
  76% of eligible patients were thrombolysed within the 30-minute standard. Prescribing of secondary prevention drugs was well within the national standard, and comparable with national averages. Audit has led to discussions between A&E and St John's Ambulance Service on how to reduce *'door to needle'* times to <60 minutes, instead of the current median time of 61minutes.

- An audit on the use of *non-invasive ventilation* in the care of Type II respiratory failure patients. This showed that type II respiratory failure is a common reason for admission to hospital, with 7 patients requiring NIV over the 8-month audit period. We were able to demonstrate that by instituting NIV early, length of hospital stay was reduced from an average of 19 days down to 15 days.

- An audit of referrals to the *Community Mental Health Team* (CMHT) was carried out in August 2005. There were 167 referrals made to the CMHT that month - on average they receive approximately 40 referrals per week. The majority (61%) of the referrals came from the GP's. Audit showed 14% of the referrals were inappropriate, and that a further 21% had no letter and therefore reason for referral was not available. Community Mental Health Nurses accepted the most referrals, 25%, followed by an associate specialist 13%.

  Audit led to discussion between the specialities on how to best to revise referral criteria to improve clinical effectiveness, with a re-audit planned in a year's time.

Clinical Risk Management (CRM)

Mrs Jean Ellyatt
Clinical Risk Manager

- **Ulysses database**
  Between May 2005 and May 2006, approximately 1,800 clinical incidents have been logged onto the Ulysses database. These relate to only those incidents reported within this period, although there are concerns that adverse clinical incident reporting may be incomplete. This is being addressed at unit level to ensure policy is followed, and that staff confidence and commitment to the process is improved. Analysis of possible adverse events is an essential approach to safeguard patient care and ensure that lessons learnt are implemented.

- **CRM meetings**

Clinical risk management meetings which are multidisciplinary and well attended continue to occur frequently in all major specialities. Recommendations made following reviews of events are followed, and necessary follow up actions taken.

- **Adverse incidents**

- Trips, slips and falls particularly, in the long stay wards are the highest reported incidents but this is not surprising considering the age and clinical condition of the many clients cared for in these areas.
- Drug errors are the second highest reported incidents. A small working group has been established to attempt to reduce the frequency of these, examining training needs and promote the *Safe and Secure Handling of Medicines* policy.

- **Further CRM activity**

The following committees also meet regularly to review relevant policy/procedures, ensure training needs are addressed, and evidence based practice is followed.

- Resuscitation Committee and Blood Transfusion Committee.
- Bi-monthly Peri-natal morbidity/mortality (M&M) meetings to review care management and Caesarean section /obstetric case reviews.
- Adult Acute Mental Health case reviews with all professionals, including GPs involved in patient management.
- Four morbidity and mortality meetings have been held in the Adult Acute Services although there remains some reluctance by surgeons to review cases. However, these will continue to be scheduled and an attendance register maintained.

- **National Confidential Enquiries**

The organisation continues to participate in reporting cases to the *National Confidential Enquiry into Patient Outcome and Death* (NCEPOD) and the *Confidential Enquiry into Maternal and Child Health* (CEMACH).

'Clinical Governance'

'Clinical governance' comprises the individual and collective measures which should be undertaken by all clinical staff to deliver and demonstrate high levels of clinical care and favourable healthcare outcomes.

'Clinical governance' is therefore an umbrella term, which covers a number of separate components – once referred to as the *'seven pillars of clinical governance'*. Activity in several of these areas has already been summarised above.

More than anything else, however, effective clinical governance is about structure and culture, - about creating an environment in which clinical excellence can flourish, and a culture in which all staff are committed to the ideal that they have a personal, professional, and collective responsibility for the standards of clinical services delivered. Progress towards this in Guernsey includes:

- The *Joint Clinical Governance Committee* (representing HSSD, MSG, GPG and the A&E contract) continues to meet quarterly to co-ordinate activities and to implement and report necessary change.

- *'Rolling out clinical governance'* is an attempt to ensure the widest understanding, involvement and support for clinical governance across all professions and all levels.

- The Chief Medical Officers Report *'Good doctors, safer patients'* proposes a process of recertification and revalidation for all doctors wishing to remain registered with the General Medical Council. This will undoubtedly impact on the way Guernsey doctors and other health professionals will need to demonstrate their own competence to continue in practice.

Vital Statistics 2005

Births and birth-related data

	Guernsey		England & Wales
	2005	5 Year Mean 1999-2003	2003
Estimated mid year resident population:	60,082*	59,807	52,790,000
• males	29,396*	28,138	25,840,000
• females	30,686*	30,669	26,950,000
• M : F	0.96	0.95	0.96
Population density/Km^2 [Area 63.1Km^2]:	952	950	51.9
Marriages:	302	349	268,500
• marriages/000	5.0	5.84	5.1
Divorces:	131	173	153,500
• divorces/000	2.2	2.9	2.9
Divorces : Marriages	0.43	0.5	0.57
Live birth registrations:	638	624	621,469
• males	338	321	318,428
• females	300	304	303,041
• M : F	1.12	1.05	1.05
Births outside marriage:	238	205	257,225
• % all births	37.3%	33%	41.4%
Stillbirths:	4	2.6	3,585
• Rate/000 live births	6.3	4.2	5.8
Infant deaths:(<1 year)	1	2.8	3,700
• infant death rate/000 LB	1.2	4.5	5.3
Crude Birth Rate/000	10.6	10.4	11.8
Natural increase per annum:	+0.19%	+0.20%	+0.16%

* includes *'natural increase'*, but excludes net migration

Vital Statistics 2005

- **Deaths and death-related data** (By ICD 10 Codes)

	Guernsey		England & Wales
	2005	5 Year Mean 1999-2003	*2003
Total deaths: (number)	525	557	538,300
• males	260	264	253,852
• females	265	296	284,400
• M : F	0.98	0.88	0.89
Crude death rate:/000	8.7	9.3	10.2
Circulatory deaths (I00-I99): No	164	200	233,058
• males - rate/00,000	285	322	377
• females - rate/00,000	261	347	401
Cancer deaths (C00-C97/D00-D48):	150	128	158,654
• males - rate/00,000	265	240	274
• females - rate/00,000	235	191	241
Lung cancer deaths (C34): No	44	26.4	28,765
• males - rate/00,000	74.8	54	66
• females - rate/00,000	39	35	43
Breast cancer deaths (C50): No	14	7	11,209
• females - rate/00,000	45.6	22.8	42
Alcoholic liver disease and cirrhosis (K70) (K74): No	4	1.2	6,786
• males - rate/00,000	6.8	2.1	16.6
• females - rate/00,000	6.5	2.0	9.3
Injury deaths (S00-X59) (including suicide): No	12	9	16,693
• males - rate/00,000	30.6	21.3	39
• females - rate/00,000	9.8	9.8	24
Suicide deaths (X60-X84): No	0	3	3,274
• males - rate/00,000	0	8.2	9.7
• females - rate/00,000	0	2.0	3.5

Note: One male death due to ,poisoning was judged of *'undetermined intent'* and one female death are still awaiting the finding of an inquest and therefore cause of death at present remains 'unclassified'

* Source: OHE *'Compendium of Health Statistics'* (17th Edition 2005-2006)

ICD10 Code	Cause of Death	Age Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+		Age All Ages	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Group I Infectious and parasitic diseases																	
A40	Streptococcal septicaemia	0	0	0	0	0	0	0	0	1	1	0	0	0	0	**1**	**1**
A41	Other Septicaemia	0	0	0	0	0	0	1	0	2	2	1	2	4	4	**8**	**8**
Total Group I		**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**3**	**3**	**1**	**2**	**4**	**4**	**9**	**9**
Group II Neoplasms																	
C10	Malignant neoplasm of oropharynx	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**1**	**0**
C15	Malignant neoplasm of oesophagus	0	0	0	0	0	0	0	0	2	0	1	2	2	0	**5**	**2**
C16	Malignant neoplasm of stomach	0	0	0	0	0	0	0	0	0	0	1	1	2	3	**3**	**4**
C18	Malignant neoplasm of colon	0	0	0	0	0	0	0	0	0	1	2	3	4	2	**6**	**6**
C20	Malignant neoplasm of rectum	0	0	0	0	0	0	0	0	0	0	0	0	0	2	**0**	**2**
C25	Malignant neoplasm of pancreas	0	0	0	0	0	0	0	0	1	1	1	0	3	4	**5**	**5**
C26	Malignant neoplasm of other and ill-defined digestive organs	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**1**	**0**
C32	Malignant neoplasm of larynx	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**
C34	Malignant neoplasm of bronchus and lung	0	0	0	0	0	0	0	0	7	2	3	3	12	7	**22**	**12**
C45	Mesothelioma	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
C50	Malignant neoplasm of breast	0	0	0	0	0	0	0	1	0	3	0	3	0	7	**0**	**14**
C56	Malignant neoplasm of ovary	0	0	0	0	0	0	0	0	0	1	0	3	0	2	**0**	**6**
C61	Malignant neoplasm of prostate	0	0	0	0	0	0	0	0	0	0	3	0	12	0	**15**	**0**
C64	Malignant neoplasm of kidney, except renal pelvis	0	0	0	0	0	0	0	0	0	0	0	1	0	0	**0**	**1**
C67	Malignant neoplasm of bladder	0	0	0	0	0	0	0	0	0	0	2	0	2	4	**4**	**4**
C71	Malignant neoplasm of brain	0	0	0	0	0	0	0	1	1	0	0	1	0	1	**1**	**3**
C73	Malignant neoplasm of thyroid gland	0	0	0	0	0	0	0	0	0	1	0	0	0	0	**0**	**1**
C74	Malignant neoplasm of adrenal gland	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
C75	Malignant neoplasm of other endocrine glands and related structures	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**
C76	Malignant neoplasm of other and ill-defined sites	0	0	0	0	1	0	0	0	0	0	0	0	1	0	**2**	**0**
C78	Secondary malignant neoplasm of respiratory and digestive organs	0	0	0	0	0	0	0	0	0	0	1	1	0	0	**1**	**1**
C79	Secondary malignant neoplasm of other sites	0	0	0	0	0	0	0	0	0	0	1	0	1	0	**2**	**0**
C80	Malignant neoplasm without specification of site	0	0	0	0	0	0	0	0	1	0	0	1	1	3	**2**	**4**
C83	Diffuse non-Hodgkin's lymphoma	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**

ICD10 Code	Cause of Death	Age Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+		Age All Ages	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
C85	Other and unspecified types of non-Hodgkin's lymphoma	0	0	0	0	0	0	0	0	0	0	0	1	1	1	**1**	**2**
C90	Multiple myeloma & malignant plasma cell	0	0	0	0	0	0	0	0	0	0	0	1	1	0	**1**	**1**
C91	Lymphoid leukaemia	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
C92	Myeloid leukaemia	0	0	1	0	0	0	0	0	0	0	0	0	0	0	**1**	**0**
C95	Leukaemia of unspecified cell type	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**
D32	Benign neoplasm of meninges	0	0	0	0	0	0	0	0	0	0	0	1	0	0	**0**	**1**
D47	Other neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
Total Group II		**0**	**0**	**2**	**0**	**0**	**0**	**0**	**2**	**14**	**9**	**17**	**22**	**45**	**39**	**78**	**72**
Group V Mental and behavioural disorders																	
F01	Vascular dementia	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**
F03	Unspecified dementia	0	0	0	0	0	0	0	0	0	0	0	0	0	6	**0**	**6**
F10	Mental and behavioural disorders due to use of alcohol	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
Total Group V		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**6**	**2**	**6**
Group VI Diseases of the nervous system																	
G12	Spinal muscular atrophy and related syndromes	0	0	0	0	0	0	0	0	0	0	0	1	1	1	**1**	**2**
G31	Other degenerative diseases of nervous system, nec	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**1**	**0**
G40	Epilepsy	0	0	1	0	0	0	0	0	1	0	0	0	0	0	**2**	**0**
G93	Cerebral anoxia	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**1**	**0**
Total Group VI		**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**2**	**1**	**1**	**1**	**5**	**2**
Group IX Diseases of the circulatory system																	
I21	Acute myocardial infarction	0	0	0	0	0	0	0	0	1	1	5	1	10	13	**16**	**15**
I25	Chronic ischaemic heart disease	0	0	0	0	0	0	0	0	2	0	3	2	8	11	**13**	**13**
I26	Pulmonary embolism	0	0	0	0	0	0	1	0	1	1	2	0	1	1	**5**	**2**
I27	Other pulmonary heart diseases	0	0	0	0	0	0	0	0	0	0	0	1	0	0	**0**	**1**
I35	Aortic stenosis	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**

ICD10 Code	Cause of Death	Age Under 1 M	Age Under 1 F	Age 1-14 M	Age 1-14 F	Age 15-24 M	Age 15-24 F	Age 25-44 M	Age 25-44 F	Age 45-64 M	Age 45-64 F	Age 65-74 M	Age 65-74 F	Age 75+ M	Age 75+ F	Age All Ages M	Age All Ages F
I42	Cardiomyopathy	0	0	0	0	0	0	0	0	1	0	0	0	1	1	**2**	**1**
I46	Cardiac arrest	0	0	0	0	1	0	0	0	0	0	0	0	1	0	**2**	**0**
I50	Heart failure	0	0	0	0	0	0	0	0	0	0	0	3	20	21	**20**	**24**
I60	Subarachnoid haemorrhage	0	0	0	0	0	0	0	0	0	1	0	1	0	0	**0**	**2**
I61	Intracerebral haemorrhage	0	0	0	0	0	0	0	0	0	0	2	0	5	0	**7**	**0**
I63	Cerebral infarction	0	0	0	0	0	0	0	0	0	0	0	1	0	1	**0**	**2**
I64	Stroke, not specified as haemorrhage or infarction	0	0	0	0	0	0	0	0	0	0	1	1	8	12	**9**	**13**
I67	Other cerebrovascular diseases	0	0	0	0	0	0	0	0	0	0	0	0	7	2	**7**	**2**
I71	Aortic aneurysm and dissection	0	0	0	0	0	0	0	0	0	0	0	0	3	2	**3**	**2**
I73	Other peripheral vascular diseases	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
I99	Other and unspecified disorders of circulatory system	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
Total Group IX		**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**5**	**3**	**13**	**10**	**64**	**67**	**84**	**80**
Group X **Diseases of the respiratory system**																	
J18	Pneumonia, organism unspecified	0	0	0	0	0	0	0	0	0	0	1	1	15	29	**16**	**30**
J20	Acute bronchitis	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
J22	Unspecified acute lower respiratory infection	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
J42	Unspecified chronic bronchitis	0	0	0	0	0	0	0	0	0	0	0	1	0	0	**0**	**1**
J43	Emphysema	0	0	0	0	0	0	0	0	0	0	0	0	2	0	**2**	**0**
J44	Other chronic obstructive pulmonary disease	0	0	0	0	0	0	2	0	0	1	2	1	9	6	**13**	**8**
J45	Asthma	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
J46	Status asthmaticus	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
J69	Pneumonitis due to solids and liquids	0	0	0	0	0	0	0	0	0	0	0	0	1	1	**1**	**1**
J81	Pulmonary oedema	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
J84	Other interstitial pulmonary diseases	0	0	0	0	0	0	0	0	2	0	0	0	2	0	**4**	**0**
J96	Respiratory failure, nec	0	0	0	0	0	0	0	0	2	0	1	0	0	1	**3**	**1**
Total Group X		**0**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**5**	**1**	**4**	**3**	**29**	**41**	**40**	**45**
Group XI **Diseases of the digestive system**																	
K22	Other diseases of oesophagus	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
K31	Other diseases of stomach and duodenum	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
K55	Vascular disorders of intestine	0	0	0	0	0	0	0	0	0	0	0	0	2	1	**2**	**1**

ICD10 Code	Cause of Death	Age Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+		Age All Ages	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
K57	Diverticular disease of intestine	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
K63	Perforated abdominal viscus	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
K65	Peritonitis	0	0	0	0	0	0	0	0	0	0	0	1	1	1	**1**	**2**
K70	Alcoholic liver disease	0	0	0	0	0	0	0	0	2	1	0	0	0	0	**2**	**1**
K72	Hepatic failure, nec	0	0	0	0	0	0	1	0	2	0	1	1	0	0	**4**	**1**
K76	Other diseases of liver	0	0	0	0	0	0	0	0	0	1	0	0	0	0	**0**	**1**
K85	Acute pancreatitis	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
K92	Other diseases of digestive system	0	0	0	0	0	0	0	0	0	0	0	0	0	2	**0**	**2**
Total Group XI		**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**6**	**2**	**1**	**2**	**3**	**7**	**11**	**11**
Group XII																	
Diseases of the skin and subcutaneous tissue																	
L03	Leg cellulitis	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
Total Group XII		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**
Group XIV																	
Diseases of the genitourinary system																	
N17	Acute renal failure	0	0	0	0	0	0	0	0	0	0	0	0	1	2	**1**	**2**
N18	Chronic renal failure	0	0	0	0	0	0	0	0	0	0	1	0	0	4	**1**	**4**
N19	Unspecified renal failure	0	0	0	0	0	0	0	0	0	0	1	0	1	4	**2**	**4**
Total Group XIV		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**2**	**10**	**4**	**10**
Group XVI																	
Certain conditions originating in the perinatal period																	
P74	Other transitory neonatal electrolyte and metabolic disturbances	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**	**0**
P95	Still birth	2	2	0	0	0	0	0	0	0	0	0	0	0	0	**2**	**2**
Total Group XVI		**3**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**2**

ICD10 Code	Cause of Death	Age Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+		Age All Ages	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Group XVIII																	
Symptoms, signs & abnormal clinical & laboratory findings, not elsewhere classified																	
R02	Gangrene, nec	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
R09	Other symptoms and signs involving the circulatory and respiratory systems	0	0	0	0	0	0	0	0	0	0	0	0	2	1	**2**	**1**
R54	Old age (senility)	0	0	0	0	0	0	0	0	0	0	0	1	6	24	**6**	**25**
R57	Shock, nec	0	0	0	0	0	0	0	0	0	0	0	1	2	2	**2**	**3**
R58	Haemorrhage, nec	0	0	0	0	1	0	0	0	0	0	0	0	1	0	**2**	**0**
R26	Abnormalities of gait and mobility	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
Total Group XVIII		**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**11**	**29**	**12**	**31**
Group XIX																	
Injury, poisoning and certain other consequences of external causes																	
S06	Intracranial injury	0	0	0	0	0	0	0	0	0	0	0	0	1	2	**1**	**2**
S09	Other and unspecified injuries of head	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**
Total Group XIX		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**2**	**2**	**2**
Group XX																	
External causes of morbidity and mortality																	
W76	Other accidental hanging and strangulation	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
X42	Accidental poisoning by and exposure to narcotics and psychodysleptics, nec	0	0	0	0	0	0	2	0	0	0	0	0	0	0	**2**	**0**
X45	Accidental poisoning by and exposure to alcohol	0	0	0	0	0	0	1	1	0	0	0	0	0	0	**1**	**1**
Y12	Poisoning by and exposure to narcotics and pschodysleptics, nec, undetermined intent	0	0	0	0	0	0	1	0	0	0	0	0	0	0	**1**	**0**
Y14	Poisoning by and exposure to other and unspecified drugs	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
	Awaiting inquest	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
Total Group XX		**0**	**0**	**0**	**0**	**0**	**0**	**4**	**1**	**3**	**0**	**0**	**0**	**0**	**0**	**7**	**1**
Total Deaths		**3**	**2**	**3**	**0**	**2**	**0**	**9**	**3**	**38**	**18**	**40**	**42**	**162**	**207**	**257**	**272**

Alderney Vital Statistics - 2005

	Males	Females	Total 2005	5 year mean 1999-2003
Population	1,114	1,140	**2,254**	2,294
• **M : F**			**0.98**	0.97
Births - In Guernsey:	8	7	**15**	9.4
Births - In Alderney:	2	2	**4**	0.8
Total Births to Alderney residents:	10	9	**19**	10.2
Births outside marriage:	4	4	**8 (42%)**	4.2 (41%)
Crude Birth Rate/000	-	-	**8.4**	4.5
Marriages registered in Alderney:			**11**	13
Deaths registered in Alderney:	10	14	**24**	22.8
Crude Death Rate/000			**10.6**	10.1
Natural Increase:*	-6 [-0.3%]		**[-0.8%]**	-12.6 [-0.6%]

*Includes 'natural increase', but excludes net migration.

[** *'Natural increase'* is the difference between the crude birth rate and the death rates, expressed as a percentage of the resident population.]

Appendix Two

A.2 Staff providing public health services 2005

Director of Public Health/Medical Officer of Health
Dr David Jeffs FRCP FFPH FAFPHM FRSH

Personal Assistant
Mrs Yvonne Kaill

Part-time Medical Staff:

Deputy Medical Officer of Health
Dr Brian Parkin MB BS BSc FRCP MRCGP DRCOG

Sexual Health Clinic
Dr Nicholas King LRCP MRCS MBBS

Guernsey Family Planning Clinic
Mrs Sue Le Page SRN

Infection Control

Mrs Elaine Burgess RSCN, ENB329/998, C&G 7307, MSc (Health Sciences)
Mrs Kay Bull RGN, ENB329/998

Environmental Health Department:

Director of Environmental Health and Pollution Regulation
Mr John Cook Chartered Environmental Health Practitioner

Deputy Chief Environmental Health Officer
Mr Tony Rowe MCIEH

Environmental Health Officers
Mr Tony Abbs Chartered Environmental Health Practitioner
Miss Christine Bell BSc (Hons) MREHIS
Mr Stan Horton MCIEH
Mr Stuart Wiltshire MCIEH

Waste Regulation Officer
Mr Simon Welch BSc(Hons)CEnv MCIWM MIOSH MIIRSM

Pest Control Operatives
Mr Paul Tostevin
Mr Michael Brache

Secretary
Ms Cristina Vincent (from January 2006)

States Analyst Laboratory

States Analyst
Dr David Mortimer BA BSc(Hons) PhD CChem FRSC MCIWEM

Mr Laurence Knight BSc (Hons) CChem MRSC
Mr Michael Hughes BSc (Hons)MIBiol
Mrs Joanne Alder BSc(Hons)
Mrs C. Joan Le Tissier HNC
Dr. Peter Atkinson BA MSc MPhil PhD
Mrs. Carol Deveau

Health Promotion Unit:

Health Promotion Manager
Miss Yvonne Le Page Bed (Hons) PgDip (HealthPromotion)

Health Promotion Officer (smoking and heart disease)
Mrs Gerry Le Roy RGN

Health Promotion Assistant (cancer)
Mrs Lucy Whitman MSc (Conservation Biology)

Resources Officer
Mrs Stephanie Charlwood

Secretary
Mrs Bella Mahy

Clinical Governance:

Clinical Risk Manager
Mrs Jean Ellyatt RGN, SCM, CMS, Cert MHS

PA to Clinical Risk Manager
Mrs Jo McGinn

Clinical Audit Nurses
Miss Morag Fitzpatrick RGN, BSc Health Studies Dip HE
(until November 2005)
Miss Eithne Downey RGN Dip HE BN MSc (Health Education)
Mrs Lynn Lewendon RGN (from September 2005)

Quality Liaison
Mrs Jennifer Guezo RN, Dip, BSc (Hons)

Health Records and Healthcare Information

Healthcare Information Manager
Mrs Allyson Huntington

Healthcare Information Analysts
Mrs Helen Jones BSc (Hons)
Mrs Tamsin Lilley BSc
(Maternity cover from June 1st 2005 to March 24 2006)

Health databases
Mrs Jenny Elliott

Health Records Manager
Mrs Jenny Powell

Clinical Coders

Senior Clinical Coder
Mrs Margaret Cann ACC

Clinical Coder
Mrs Sue Sheppard